Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Durable Medical Equipment Regional Carriers

Meeting HCFA's Objectives

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EXECUTIVE SUMMARY

PURPOSE

To determine if Durable Medical Equipment Regional Carriers met the Health Care Financing Administration's implementation objectives.

BACKGROUND

On October 1, 1993, the Health Care Financing Administration (HCFA) began using four Durable Medical Equipment Regional Carriers (DMERCs) to process Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims for Medicare payment. Prior to the DMERCs, HCFA used 34 carriers to process all Part B claims, including those for DMEPOS.

The change to four DMERCs was an effort by HCFA to improve ineffective and costly claims processing under the 34 carrier system. Specifically, HCFA was concerned with ineffective education and outreach efforts, a lack of basic data for fraud prevention, a lack of claims processing expertise for medical equipment and supplies, a lack of standardized forms for claims processing, and "carrier shopping" by suppliers for the highest reimbursement rates among carriers.

HCFA charged the DMERCs with establishing medical policies for the 100 items that had the highest allowed charges, developing aggressive education and fraud prevention programs, and reducing claims processing costs. At the same time, HCFA required all Medicare carriers to use a standard claims form and changed its claims jurisdiction policy. HCFA designed these initiatives to reduce both administrative costs and costs to the Medicare Trust Fund.

FINDINGS

DMERCs Established Most Medical Policies as Required

By October 1, 1993, the DMERCs were to establish medical policies defining the circumstances under which the 100 DMEPOS items that had the highest allowed charges were to be paid. They did so for 87 of the targeted DMEPOS items. Eight of the remaining policies were finalized in 1995 and two were finalized in 1997. An additional two items were dropped from consideration, and a policy for the remaining item has yet to be developed.

DMERCs are Providing Education as Required

HCFA charged the DMERCs with developing an aggressive educational component, with the purpose of reducing incorrect claims submission, as well as reducing fraud. DMERCs have responded with a series of educational seminars directed at suppliers, physicians and beneficiaries, as well as a focused effort to educate particular suppliers that have a history of billing problems.

DMERC Fraud Units Experienced Excellent Outcomes on Individual Fraud Cases, but Their Overall Effectiveness is Unclear

HCFA charged the DMERCs to make a concerted effort to reduce fraud in DMEPOS billing and payments. DMERCs are attacking fraud in many specific cases; however, a lack of complete information precluded us from determining the effectiveness of DMERC fraud unit activities. While we obtained some workload data that quantifies their fraud efforts, the DMERCs did not provide needed data that documented the quality and result of their efforts.

DMERCs Succeeded in Decreasing Claims Processing Costs

Claims processing costs for DMEPOS claims have declined by 15 percent since the DMERCs were established, from $1.17 per claim in 1995 to $1.00 per claim in 1998. Accordingly, the DMERCs have saved an estimated $37 million per year compared to pre-DMERC costs. This was done largely through HCFA's initiative to standardize claims forms and increase use of electronic claims submission. In addition, DMERC medical expertise has contributed substantially to Medicare Trust Fund savings.

HCFA's Claims Jurisdiction Policy Stopped Carrier Shopping

To prevent carrier shopping, HCFA dropped its point of sale billing policy and adopted a beneficiary residence jurisdiction policy. This action prevented suppliers from shopping for specific carriers that would give the most favorable reimbursement. Under the new policy, carriers were predetermined, based on where the beneficiary who received DMEPOS lived.

DMERC Activities Produced Positive Results

Concurrent with implementing the activities described above, the DMERCs worked cooperatively with the HCFA, the Statistical Analysis Durable Medical Equipment Regional Carrier, the Office of Inspector General, and others to improve Medicare claims processing and prevent fraud, waste, and abuse. Such cooperative efforts led to development and revision of various policies, and changes in claims processing practices. The changes in policies and practices led to financial savings in several operational areas, including wound care supplies, lymphedema pumps, incontinence supplies, and orthotics.

RECOMMENDATION

Overall, the DMERCs generally met HCFA's objectives. However, one area of uncertainty is the effectiveness of their fraud units. To facilitate measurement of fraud unit effectiveness, we recommend that HCFA require the DMERCs to maintain needed data in their automated fraud information systems. This data should include complete and accurate documentation on the sources of opened cases and detailed financial information on fraud cases in overpayment status. Such data would facilitate an analysis of not only the quantity of the fraud units' efforts, but also the quality.

COMMENTS

The HCFA concurred with our recommendation that the DMERCs maintain additional data in their automated fraud information systems. HCFA is currently developing a Program Integrity Management Reporting system which will require Medicare contractors to report data on fraud and abuse overpayments status. The new system is scheduled for implementation during Fiscal Year 2000. The full text of their comments is in appendix A.